STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

POC Attached + approved 3/6/19 SHN

January 25, 2019

Garrett Havican, President
The Hospital Of Central Connecticut
100 Grand Street
New Britain, CT 06050

Dear Mr. Havican:

Unannounced visits were made to The Hospital Of Central Connecticut commencing on September 24, 2018 and concluding on October 24, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations, a licensing renewal inspection and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits. The state violations cannot be edited by the provider in any way.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by February 8, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by February 8, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

DATES OF VISIT: Commenced on September 24, 2018 and concluded on October 24, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

An office conference has been scheduled for February 26, 2019 at 1:00 P.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please be prepared to discuss those violations identified with an asterisk.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:lst

CT #'s 22794, 21969, 21905, 23220, 22553, 24021, 22928, 21465, 20811,
21753, 21442, 22513, 23705, 21108, 22685, 23828, 23798, 22140, 21935
22653, 23657, 22800, 20489, 21148, 21077, 22188

DATES OF VISIT: Commenced on September 24, 2018 and concluded on October 24, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

1. *Based on a clinical record reviews, staff interviews and a review of the hospital's policies and procedures for four of ten patients reviewed for the use of medications to manage a patient's behavior (Patient #27, #56, #57 and #58), the hospital failed to ensure that the physician or Licensed Independent Practitioner (LIP) documented a comprehensive assessment for the use of psychoactive medications and/or a response to the medication and/or failed to have a policy that defined what constituted the use of drugs or medications as a restraint and/or failed to have a policy that directed a reassessment after medication administration. The findings include:

   a. Patient #27 was admitted to the hospital on 10/14/16 after a fall at home that resulted in a left comminuted fracture of the humeral neck. On 10/14/16 at 11:30 PM, physician's orders directed the use of an enclosure bed as the patient was confused and attempting to get out of bed. Review of the physician's orders dated 10/15/16 at 1:41 AM directed Haldol 2 milligrams (mg) intravenous (IV) times one. Review of the medication administration record (MAR) indicated Haldol 2 mg IV was administered on 10/15/16 at 1:46 AM. Review of the physicians and nurses notes failed to document a rationale/assessment and/or response for the administration of Haldol.
   b. Patient #56 was admitted to the hospital on 9/27/18 with diagnosis that included cerebral vascular accident, acute kidney injury, intracranial atherosclerosis and carotid artery stenosis. On 10/16/18 at 6:41 PM, physician's orders directed the use of an enclosure bed as the patient was confused and interfering with medical treatment. Review of the physician's orders dated 10/17/18 at 1:14 PM directed Haldol 5 mg intramuscular (IM). Review of the MAR indicated that Haldol 5 mg IM was administered on 10/17/18 at 1:49 PM. Review of the physicians and nurses notes failed to document a rationale/assessment and/or response for the administration of Haldol.
   c. Patient #57 was admitted to the hospital on 7/3/18 for sepsis secondary to aspiration pneumonia. On 7/5/18 at 10:00 PM, a physician's order directed the use of an enclosure bed due to interference with medical treatment for behaviors of confusion, agitation and restlessness. Review of the physician's orders dated 7/5/18 at 8:44 PM directed Haldol 0.5 mg IV every six hours as needed for agitation. Review of the MAR indicated Haldol 0.5 mg IV was administered on 7/5/18 at 9:48 PM. Review of the physicians and nurses notes failed to document a rationale/assessment and/or response for the administration of Haldol.
   d. Patient #58 was admitted to the hospital on 5/17/18 for a small bowel obstruction, pneumonia and developed atrial fibrillation. Patient #58 became confused during the course of his/her hospitalization and a physician's orders dated 5/21/18 directed Haldol 2.5 mg IV every eight hours as needed for agitation. Review of the MAR indicated Haldol 2.5 mg IV

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was administered on 5/22/18 at 12:05 AM. Subsequent to the medication administration a physician's order dated 5/22/18 at 12:46 AM directed a bilateral padded mitt for interference with medical treatment. Review of the physicians and nurses notes failed to document a rationale/assessment and/or response for the administration of Haldol.

Interview with the Chief of Psychiatry on 10/24/18 indicated the physician or LIP should have documented an assessment, rationale and response for the administration of psychoactive medications to manage a patient's behavior. In addition, the Chief of Psychiatry identified the hospital failed to have a policy that defined a description of what constituted the use of medications as a restraint.

Interview and review of the medical record's # 27, #56, #57 and #58 with Nurse Manager #3 on 10/23/18 identified that the nurse should have documented a response to the administration of an as needed medication and did not. The hospital policy entitled Medication Orders and Administration failed to direct a reassessment of medication after medication administration.

Subsequent to the surveyor's inquiry and findings an immediate action plan dated 10/24/18 directed that when as needed medications were administered, the physician's and LIP's would indicate the rational for the use of the medication and both the medical and nursing staff would assess the patient for their effectiveness.

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2. Based on a clinical record reviews, staff interviews and a review of the hospital's policies and procedures for four of ten patients reviewed for restraints (Patient #27, #55, #56 and #57), the hospital failed to correctly specify the reason for the restraint type.
   a. Patient #27 presented to the hospital on 10/14/16 after a fall at home that resulted in a left comminuted fracture of the humeral neck. On 10/14/16 at 11:30 PM, physician's orders directed the use of an enclosure bed as the patient was confused, attempting to get out of bed and interfering with medical treatment.
   b. Patient #55 was admitted to the hospital on 10/18/18 with an acute ischemic stroke. On 10/19/18, a physician's ordered directed an enclosure bed due to interference with medical treatment, cognitive impairment and risk for injury.
   c. Patient #56 was admitted to the hospital on 9/27/18 with diagnosis that included cerebral vascular accident, acute kidney injury, intracranial atherosclerosis and carotid artery stenosis. On 10/16/18 at 6:41 PM physician's orders directed the use of an enclosure bed as the patient was confused and interfering with medical treatment.
   d. Patient #57 was admitted to the hospital on 7/3/18 for sepsis secondary to aspiration pneumonia. On 7/5/18 at 10:00 PM, a physician's order directed the use of an enclosure bed

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due to interference with medical treatment for behaviors of confusion, agitation and restlessness.

Interview with the Director of the Hospitalist Program and Nurse Manager #3 on 10/23/18 identified an enclosure bed would not prevent interference with medical treatment such as intravenous lines, urinary catheters and oxygen equipment as the patient would still have use of their extremities and hands, therefore the order failed to correctly specify the reason for the restraint. Interview with the Chief of Psychiatry on 10/24/18 indicated a physician's order for the use of a restraint should be ordered and correlated with the proper type and justification for its use.

Subsequent to the surveyors inquiry, an immediate action plan dated 10/24/18 directed that education would be provided to clinical staff that identified the patient's behavior would match the type of restraint being utilized.

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3. *Based on a clinical record review, staff interviews and a review of the hospital's policies and procedures for five of ten patients reviewed for restraints (Patient #8, #27, #55, #56 and #57), the hospital failed to ensure the least restrictive measures were utilized. The finding included:
   a. Patient #8 was admitted to the hospital on 6/3/17 for new onset seizure activity. Patient #8 was also being treated for hyperkalemia, metabolic acidosis, uncontrolled hypertension and delirium. On 6/4/17 at 9:00 PM, a physician's order directed bilateral wrist restraints due to interference with medical treatment for behaviors of agitation and restlessness. Review of the nursing restraint flow sheet dated 6/4/17 identified alternate measures that were attempted and unsuccessful included a bed alarm, redirection, de-escalation techniques, a safe environment and medication management.
   b. Patient #27 presented to the hospital on 10/14/16 after a fall at home that resulted in a left comminuted fracture of the humeral neck. On 10/14/16 at 11:30 PM, physician's orders directed the use of an enclosure bed as the patient was confused and attempting to get out of bed. Review of the nursing restraint flow sheet dated 10/14/16 identified alternate measures that were attempted and unsuccessful included a bed alarm, comfort measures, decreased stimuli, diversion, frequent checks, reorientation, verbal limit setting and a proximity close to the nurse's station.
   c. Patient #55 was admitted to the hospital on 10/18/18 who was admitted with an acute ischemic stroke. On 10/19/18 at 9:30 PM, a physician's ordered directed an enclosure bed due to interference with medical treatment, cognitive impairment and risk for injury. Review of the nursing restraint flow sheet dated 10/19/18 identified alternate measures that were attempted and unsuccessful included a bed alarm, de-escalation and relaxation techniques, redirection and a physically safe environment.

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d. Patient #56 was admitted to the hospital on 9/27/18 with diagnosis that included cerebral vascular accident, acute kidney injury, intracranial atherosclerosis and carotid artery stenosis. On 10/16/18 at 6:41 PM physician's orders directed the use of an enclosure bed as the patient was confused and interfering with medical treatment. Review of the nursing restraint flow sheet dated 10/16/18 identified alternate measures that were attempted and unsuccessful included a bed and chair alarm. Interview with RN #3 on 10/22/18 indicated she had requested one to one care for Patient #56 and was told by nursing leadership that staffing would not allow that level of observation. On 10/23/18, the enclosure bed was discontinued.

e. Patient #57 was admitted to the hospital on 7/3/18 for sepsis secondary to aspiration pneumonia. On 7/5/18 at 10:00 PM, a physician's order directed the use of an enclosure bed due to interference with medical treatment for behaviors of confusion, agitation and restlessness. Review of the nursing restraint flow sheet dated 7/5/18 identified alternate measures were attempted and unsuccessful included a bed alarm, de-escalation techniques and redirection.

Interview and review of the clinical records of Patient #8, #27, #55, #56 and #57 with Nurse Manager #3 on 10/23/18 indicated that a one to one observation was not implemented as a least restrictive measure prior to the use of an enclosure bed. Further interview with Nurse Manager #3 indicated she was provided education that identified enclosure beds were the least restrictive measure.

The hospital policy entitled restraints and seclusion directed in part that restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff member or other from significant risk or harm.

The hospital policy entitled Inpatient observation directed in part that the registered nurse would assess each patient's needs and risk with the goal to provide as safe and therapeutic environment using the least restrictive interventions. Further review identified that direct observation of one patient was deemed for patients who are assessed to be high risk of injury to self or others, exhibit impulsive or who have unpredictable behaviors.

Subsequent to the surveyor's inquiry, an immediate action plan dated 10/24/18 identified that nursing documentation of attempts for least restrictive interventions would include the utilization of one to one observation.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (e) Nursing service (1).

4. Based on a clinical record review, staff interviews and a review of the hospital's policies and

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procedures for one of ten patients reviewed for restraints (Patient #8), the hospital failed to discontinue restraints at the earliest time possible in accordance with the hospital policy.

a. Patient #8 was admitted to the hospital on 6/3/17 for new onset seizure activity. Patient #8 was also treated for hyperkalemia, metabolic acidosis, uncontrolled hypertension and delirium. On 6/5/17 at 7:38 PM the physicians order directed bilateral wrist restraints due to interference with medical treatment for behaviors of agitation and restlessness. Review of the nursing restraint flow sheet dated 6/5/17 identified from 1:00 AM to 5:00 AM Patient #8 was asleep.
Interview with Nurse Manager #3 on 10/23/18 indicated restraints should be discontinued when a patient has been asleep in accordance with the hospital policy.

The hospital policy entitled restraints and seclusion directed in part that the use of restraints would not occur longer than absolutely necessary and the criteria included an improved mental status, the behavior that led to the restraint had improved, the capacity to agree to the expected behavior, the time limit of the order had expired and the management by less restrictive measures was successful.

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5. *Based on a clinical record review, staff interviews and a review of the hospital's policies and procedures for three of ten patients reviewed for restraints (Patient # 55, #56, #57), the hospital failed to document supporting evidence by a physician or Licensed Independent Practitioner (LIP) for the use and/or continued use of the restraint and/or failed to have a policy that directed the provider to document the rationale and/or assessment for the use of the restraint in the clinical record. The findings include:
   a. Patient #55 was admitted to the hospital on 10/18/18 with an acute ischemic stroke. On 10/19/18 at 9:30 PM, a physician's ordered directed an enclosure bed due to interference with medical treatment, cognitive impairment and risk for injury. The enclosure bed was reordered from 10/20/18-10/22/18.
   b. Patient #56 was admitted to the hospital on 9/27/18 with diagnosis that included cerebral vascular accident, acute kidney injury, intracranial atherosclerosis and carotid artery stenosis. On 10/16/18 at 6:41 PM physician's orders directed the use of an enclosure bed as the patient was confused and interfering with medical treatment. The enclosure bed was re-ordered on 10/17/18-10/23/18.
   c. Patient #57 was admitted to the hospital on 7/3/18 for sepsis secondary to aspiration pneumonia. On 7/5/18 at 10:00 PM, a physician's order directed the use of an enclosure bed due to interference with medical treatment for behaviors of confusion, agitation and restlessness. The enclosure bed was re-ordered on 7/6/18.

   Interview and review of the physician's progress notes with Nurse Manager #3 on 10/23/18

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failed to identify that daily clinical notes reflected an assessment and/or justification for continued restraint for Patients #55, #56 and #57. Furthermore, the hospital policy entitled Restraints and Seclusion failed to identify that daily restraint documentation was required by the physician or LIP.

Interview with the Chief of Psychiatry on 10/24/18 indicated a daily assessment from the physician or LIP should be conducted with documentation in the clinical record that identifies the justification for the restraint, its continued use, and that alternate methods that were not successful.

Subsequent to the surveyor's inquiry, an immediate action plan dated 10/24/18 directed in part that the medical staff would receive education to ensure daily assessments and documentation regarding the rationale and continued use of restraints if applicable.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing service (1) and/or (i) General (6).

6. Based on a clinical record reviews, staff interviews and a review of the hospital's policies and procedures for two of ten patients reviewed for restraints (Patient #56 and #58), the hospital failed to monitor the patient in accordance with the hospital policy. The findings include:
   a. Patient #56 was admitted to the hospital on 9/27/18 with diagnosis that included cerebral vascular accident, acute kidney injury, intracranial atherosclerosis and carotid artery stenosis. On 10/17/18 at 6:00 PM, physician's orders directed the use of an enclosure bed as the patient was confused and interfering with medical treatment. Review of the nursing flow sheets on 10/18/18 identified restraint monitoring including range of motion, circulation, sensation, movement, respiratory status, hygiene, nutrition and elimination. Further review identified that monitoring failed to be conducted on 10/18/18 from 4:01 PM through 7:59 PM.
   b. Patient #58 was admitted to the hospital on 5/17/18 for a small bowel obstruction, pneumonia, and developed atrial fibrillation. Patient #58 became confused during the course of his/her hospitalization and a physician's order dated 5/22/18 at 12:46 AM directed a bilateral padded mitt for interference with medical treatment. Review of the nursing flow sheets on 5/22/18 identified restraint monitoring including range of motion, circulation, sensation, movement, respiratory status, hygiene, nutrition and elimination. Further review identified that monitoring failed to be conducted on 5/22/18 from 3:01 AM through 7:31 AM when the restraint was discontinued.

   Interview with Nurse Manager #3 on 10/23/18 indicated restraint monitoring should have been conducted for Patient #56 and #58 every two hours and was not.

   The hospital policy entitled restraints and seclusion directed in part restraint monitoring would be conducted and documented every two hours for signs of injury, hygiene, food, fluids, elimination, range of motion, vital signs, mental status, physical and psychological

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status, adequate peripheral circulation, the need for less restrictive interaction or discontinuation of restraints and proper application and release from the restraint.

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7. *Based on a clinical record reviews, staff interviews and a review of the hospital's policies and procedures for two of ten patients reviewed for restraints (Patient #55 and #56), the hospital failed to document adequate justification for the use of more than one restraint.

   The findings include:

   a. Patient #55 was admitted to the hospital on 10/18/18 with an acute ischemic stroke. On 10/19/18 at 9:30 PM, a physician's ordered directed an enclosure bed due to interference with medical treatment, cognitive impairment and risk for injury. Further review identified that the enclosure bed was reordered from 10/20/18 through 10/22/18. Physician's orders dated 10/20/18 directed bilateral mitts due to interference with medical treatment.
   b. Patient #56 was admitted to the hospital on 9/27/18 with diagnosis that included cerebral vascular accident, acute kidney injury, intracranial atherosclerosis and carotid artery stenosis. On 10/16/18 at 6:41 PM, physician's orders directed the use of an enclosure bed as the patient was confused and interfering with medical treatment. Further review identified that the enclosure bed was re-ordered on 10/17/18 through 10/23/18. Physician's orders dated 10/20/18 at 8:54 AM through 10/23/18 directed bilateral wrist restraints for the interference with medical treatment.

   Interview with Nurse Manager #3 and the Director of the Hospitalist Program on 10/23/18 indicated that each restraint type for Patient #55 and #56 should have had its own justification for use and did not.

   The hospital policy failed to identify the procedure and/or steps to be conducted when more than one restraint was used simultaneously.

   Subsequent to the surveyor's inquiry, an immediate action plan dated 10/24/18 indicated education would be provided that directed justification for the use of each restraint and the behavior would correspond with the restraint type.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(i) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (l) General (6).

8. *Based on observations, interview, and review of facility policies, the hospital failed to ensure that one of sixteen patients' dialyzing (#46), had their access site visible at all times in accordance with facility policy. The finding includes:
    a. Observation on 9/25/18 at 9:50 AM Patient #46 was being dialyzed via a right central venous catheter (CVC). During the observation the catheter site and connections were unable to be visualized. Interview with the Manager on 9/25/18 at 11:15 AM stated the access site should be visible at all times and subsequently uncovered the site. Facility policy directed that the access site is visualized at all times throughout the hemodialysis treatment.

    Upon request the facility provided the Department with an immediate action plan that included in part, that staff were reeducated on the importance of ensuring sites are uncovered, and all patients were reeducated and received a handout on the importance of keeping their sites uncovered.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(i) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (l) General (6).

9. *Based on observations, interviews, and review of facility policies, the hospital failed to ensure that following an unscheduled reverse osmosis sanitation, that the water loop was tested for absence of sterilant prior to the start of the treatment day. The finding includes the following:
    a. On 09/25/18 at 9:45 AM during documentation review and subsequent interview of the facility water tech and facility dialysis manger, it was identified that on 08/06/18 at 6:45 PM the water loop had been sanitized by a facility contractor for the reverse osmosis machine and water loop. The logs for 08/07/18 failed to indicate that the loop was tested for absence of sterilant prior to the start of the treatment day.

    Immediately following recognition that the technician safety check was not documented, the facility departments involved with the RO sanitization process were immediately notified and an immediate plan was provided to the Department to ensure securement of the water room and notification of all disciplines involved in the RO sanitization moving forward. Beginning 9/26/2018, the process for unscheduled RO sanitization that is completed by the RO system maintenance provider was reviewed. The Dialysis staff will be responsible for notifying the Plant Operations and Maintenance Department that the RO system was put on deionization, (DI). The Plant Operator will contact the RO

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system maintenance provider and the on-call Biomedical Engineering tech to notify them that technicians will be needed to sanitize the loops later in the day after patient treatments are completed. The RO system maintenance provider will sign-in in the Plant Operations and Maintenance Department upon arrival, the on call Biomedical Engineering Technician will escort the RO system maintenance provider to the Dialysis Unit, the RO system maintenance provider will sanitize the loop, Biomedical Engineering will sanitize from the wall station to the machines and will verify after the rinse by documentation in the monthly RO Sterilization Log that the stations and machines are absent of sterilant, the next morning the Dialysis technicians will perform a safety check of the RO loop at each station and will document absence of sterilant results on the RO sanitization log.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (j) Clinical Records (3).

10. Based on clinical record review, interview and policy review, the hospital failed to ensure that the physician as part of the Interdisciplinary team, conducted comprehensive assessments for ten of ten patients reviewed (Patient #40-49) in accordance with facility policy. The finding includes:
    a. Review of the clinical records of Patients #40-49 failed to reflect that the physician conducted individualized and comprehensive assessments of each patient. Review of the policy indicated that each member of the interdisciplinary team is responsible to provide each patient with an individualized and comprehensive assessment of his or her needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(i) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (j) Clinical Records (3).

11. Based on a review of clinical records, interview and review of policy, for two patients who experienced a health decline (Patient # 48 and #42), the hospital failed to complete a comprehensive assessment to determine stability status. The findings include:
    a. Patient #48 was admitted to the unit in January 2018. Review of the clinical record identified that s/he was hospitalized during the period of 4/24/18 through 4/30/18 and 5/1/18 through 5/17/18. The clinical record failed to reflect that a 90 day comprehensive assessment was completed and/or that the patient was reassessed after extended hospitalizations.
    b. Patient # 42 had a diagnosis of end stage renal disease and received peritoneal dialysis at home. Review of the clinical record identified that the patient lived with the daughter and walked independently. An orthopedic note dated 4/19/18 noted that the patient fell resulting in a patella tendon rupture and a bimalleolar ankle fracture that required surgery. The patient was non-weight bearing and went to a skilled nursing facility for rehabilitation. The record indicated that the patient's albumin level ranged from 1.8

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grams per deciliter to 2.5 (goal 4.0) during the period of 7/3/18 through 9/14/18. The registered dietitians note dated 9/14/18 reflected that the patient had a significant weight loss of 11.4% in three months, unplanned. Review of the clinical record with the PD RN failed to identify that the IDT team conducted an assessment when the patient experienced multiple changes in condition. Interview with the Manager on 9/26/18 at 2:30 PM stated that the facility does not have a system for tracking potentially unstable patients. Review of the facility policy indicated that an interdisciplinary assessment needs to be completed within 30 days of admission, 90 days after the initial, and annually. The policy failed to address the need for an assessment of a potentially unstable patient.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(ii) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3).

12. Based on a review of facility documentation and interview, the hospital failed to ensure that serum albumins were tracked/trended and actions were implemented to maximize the number of patients to achieve a desired albumin level of 4.0. The findings include the following:
    a. Review of the quality assurance meeting minutes and quality data identified a facility goal for less than 65.8% of the patients to have an albumin level less than 4.0. Review of the data for the period of January 2018 through July 2018 the facility had 71% to a high of 80% of the hemodialysis patients with an Albumin less than 4.0. The data indicated that on December of 2017; 60.3% of the patients had an albumin less than 4.0 however in January 2018 that number increased to 75.40%. The meeting minutes failed to reflect that an action plan was instituted. Review of the March 2018 quality minutes indicated that 79% of the patients were not meeting goal and the comments were goal not met continues as an area for opportunity for improvement, dietitian working with patients to improve compliance. The April data indicated 79.9% of patients were not meeting goal however there was no mention of this or revision of the action plan in the minutes.

       Review of the quality documentation for the period of 1/18 through 7/18 failed to reflect that a comprehensive plan was completed to address the suboptimal results and/or that the data was reviewed at each meeting and revised to address the lack of improvement.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(i) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (j) Clinical Records (3).

13. Based on a review of clinical records and interview for eight (8) of eight (8) hemodialysis records reviewed (Patient #43, 44, 45, 46, 47, 48, 49, 50), the hospital failed to ensure that the treatment records reflected the dialysis flow rate (DFR) delivered rendering an inability to determine if the treatment order was followed. The finding includes:

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a. Review of the hemodialysis treatment sheets for Patient #43, 44, 45, 46, 47, 48, 49, 50 during the period of 9/1/18 through 9/20/18 failed to reflect documentation of the dialysis flow rate (DFR) that was delivered. Review of the records with the Manager on 9/25/18 identified that she was unable to locate documentation of the DFR delivered on the treatment sheets.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(i) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3) (A) and/or (g) Nurse Manager (3) and/or (l) General (6).

14. Based on observation and policy review the hospital failed to ensure that the dialysis station was thoroughly disinfected between patients in accordance with facility policy. The finding includes the following:
    a. On 9/27/18 at 10:40 AM, LPN #1 was observed cleaning the dialysis machine at Station #8. LPN #1 failed to thoroughly disinfect the primer container and/or disinfect the chase box as part of the dialysis station. Review of the infection control policy directed that all equipment and supplies should be considered as potentially blood contaminated. All work surfaces including the dialysis machine should be cleaned with a bleach solution

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (h) Nursing Staff (4).

15. Based on a review of clinical records, interview, and policy review for three (3) of eight (8) patients reviewed for dialysis prescription (#48, 45, 47), the hospital failed to ensure that the blood flow rates (BFR) were administered as prescribed and/or that the physician was notified when the BFR could not be achieved. The findings include the following:
    a. Patient #48 was admitted to the unit in January 2018. Review of the order directed a BFR of 400 ml/min during his/her 3 hour treatment. Review of the treatment sheets dated 9/6/18, 9/8/18, 9/11/18, 9/14/18, 9/15/18, 9/18/18, 9/20/18, 9/22/18 and 9/25/18 failed to reflect that the BFR directed by the physician was delivered.
    b. Review of Patient #45's physician orders directed a BFR of 300-350 ml/min for a 3.5 hour treatment. Review of the plan of care (POC) dated 9/17/18 indicated that the patent had a suboptimal Kt/v of 1.041 on 9/11/18 (goal >1.3) with the intervention of a BFR of 350 ml/min. Review of the treatment sheets dated 9/15/18, 9/18/18, 9/20/18, 9/22/18 and 9/25/18 indicated that the BFR delivered was 300-330 ml/min. The facility failed to ensure that the BFR orders clearly directed the BFR to be administered and/or that the plan of care was followed to assist the patient in achieving a therapeutic Kt/v.
    c. Review of Patient #47's physician's orders dated 7/31/18 directed a BFR to a maximum of 450 ml/min. Review of treatment flow sheets dated 8/21/18, 9/4/18, 9/6/18, 9/15/18 and 9/22/18 indicated that the BFR delivered ranged from 200 ml/min to 400 ml/min. The record failed to identify a rationale for the fluctuating BFR's. The clinical record

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indicated that on 8/2/18 the patient had a Kt/v of 1.55 however on 9/6/18 the patient's Kt/v decreased to 1.070 ml/min. Review of the policy indicated that the blood flow rate is based on the needle size and the arterial and venous pressures, however does not incorporate the physician's order.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (j) Clinical Records (3).

16. Based on clinical record review, interview and policy review, for three (3) of eight (8) patients reviewed for care plans (Patient #45, 42, and 40), the hospital failed to ensure that an RN assessment was completed before the development of the plan of care and/or the care plan was comprehensive to meet the individualized needs of the patient. The findings include the following:
    a. Review of the clinical record for Patient #45 indicated that the patient started at the facility in August 2018. The record indicated that a plan of care was completed on 9/17/18, however the record failed to reflect that a RN comprehensive assessment had been completed prior to the completion of the plan of care. Review of the care plan failed to identify that the patient was included in the development of the plan. Interview with the Manager on 9/27/18 at 3:00 PM indicated that patients are not included in the care planning process since the institution of their new computer system. Review of the policy indicated that the interdisciplinary patient assessment and plan of care needs to be completed by the four disciplines physician, RN, Social Worker and Dietician. After each discipline competes their section of the form, the team meats to develop the care plan.
    b. Patient #42 had a diagnosis of end stage renal disease and received peritoneal dialysis at home. Review of the clinical record identified that the patient's primary language was Spanish, lived with his/her daughter, and walked independently. An orthopedic note dated 4/19/18 noted that the patient fell resulting in a patella tendon rupture and a bimalleolar ankle fracture that required surgery. The patient was non-weight bearing and required a skilled nursing facility for rehabilitation. The record indicated that the patient's albumin level ranged from 1.8 grams per deciliter to 2.5 (goal 4.0) during the period of 7/3/18 through 9/14/18. The registered dietitians note dated 9/14/18 reflected that the patient had a significant unplanned weight loss of 11.4% in three months. Review of the clinical record with the PD RN failed to identify that the plan of care was revised to include the aforementioned changes in the patients' status.
    c. In addition, review of Patient #42's home cycler treatment records during the period of 5/5/18-9/9/18 failed to reflect that the records were complete missing numerous required sections including but not limited to: weight, blood pressure, evidence of swelling, solution %, initial drain amount, total UF, average dwell, and exit site appearance. The record lacked gaps of time where no treatment records were brought in during monthly visits and/or documentation that the skilled nursing facility was contacted when long

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term care nurses administered the PD. Interview with the PD RN stated she would remind the patient to bring in the treatment records but didn't update the care plan to determine what the compliance issue was and/or how to improve the problem.

d. Patient #40 had a diagnosis of end stage renal disease and received hemodialysis three times a week. A physician's note dated 3/1/18 identified that the patient's blood pressure support was dependent on volume status and s/he was very sensitive to volume removal, dry weight increased to 110 kilograms. Review of the treatment records during the period of 4/17/18-6/7/18 noted that the patient had episodes of hypotension that ranged from 75/41-100/56. An annual assessment and corresponding care plan dated 7/31/18 identified under fluid status/blood pressure/estimated dry weight, a potential alteration in target goal related to hypotension. The plan lacked interventions to address this problem. On 9/25/18 at 9:45 AM, the patient was observed receiving hemodialysis and had a documented blood pressure (BP) of 83/50 and at 10:15, the patient's BP was 87/55. Review of the care plan with the charge nurse on 9/25/18 at 11:30 AM stated the care plan was not reflective of interventions staff may try during treatment to address BP issues and should have been.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (j) Clinical records (3).

17. Based on a review of clinical records and interview, or two of five patients reviewed for monthly notes (#40 and 41), the hospital failed to ensure nursing notes were written in accordance with facility expectation. The findings include the following:

    a. Patient #40 had a diagnosis of end stage renal disease and received hemodialysis three times a week. Review of the clinical record and interview with the charge nurse on 9/25/18 at 1PM failed to identify that monthly nurses notes were written during the period of 8/17-3/18 and 5/18. The charge nurse stated that nurses are responsible to document monthly or more often as needed.

    Patient #41 had a diagnosis of end stage renal disease and received hemodialysis three times a week. Review of the clinical record and interview with the charge nurse on 9/25/18 at 1:30 PM failed to identify that monthly nurses' notes were written for the months of April 2018, July 2018 or August 2018 and should have been.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D55a (c) Governing Body (1)(B)(i) and/or (d) Administrator/Director (2) and/or (e) Medical Director (3)(A) and/or (g) Nurse Manager (3) and/or (5).

18. Based on review of facility documentation and interview the facility failed to ensure that staffing met the Regulations of CT State Agencies. The findings include the following:

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a. Review of the staffing sheets for the period of 8/20/18 through 9/15/18 indicated that on four occasions the charge nurse had a patient care assignment after 3:00 PM. Interview with the Manager on 9:26 at 3:15 PM indicated that when this occurs the Assistant Nurse Manager stays and assumes the Charge Nurse role however the facility documentation failed to reflect this change.
b. Review of the staffing on 9/13/18 indicated that a LPN had a four patient assignment. Review of the acuities indicated that 2 patients were "level A" requiring a 4:1 patient to nurse ratio and the other two patients were "level B" requiring a 3 to 1 patient nurse ratio. Interview with the Assistant Nurse Manager on 9/26/28 indicated that the facility does not have a mechanism that incorporates the acuities into staffing patterns.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (d) Medical records (3) and/or (e) Nursing service (1).

19. Based on a review of clinical records, interview, and policy review, for two of three care plans reviewed at the wound center (Patient #53 and #54), the facility failed to ensure the plans of care were comprehensive to include contact precautions. The findings include:
    a. Patient #53 was admitted to the clinic on 7/23/18 with diagnoses that included vasculitis. Review of the clinical record identified that a plan of care was developed on 7/23/18 that identified in part, impaired tissue integrity; soft tissue infection with interventions to assess signs and symptoms of infection every visit and provide patient with education on signs/symptoms of infection. The care plan failed to indicate the location of the soft tissue infection. Review of laboratory results dated 7/28/18 identified that the patient had methicillin resistant staphylococcus aureus (MRSA) in the leg wound. Review of the record failed to indicate that the plan of care was updated to include the MRSA infection. Review of the care plan with the Clinic Director on 10/16/18 at 12:55 PM stated staff should have updated the care plan to include the MRSA infection.
    b. Patient #54 was admitted to the clinic on 6/20/18 with diagnoses that included history of MRSA, and was treated at the wound clinic for a right lateral lower leg and left lower leg wounds. Review of the clinical record identified that a plan of care was developed on 6/20/18 that identified impaired tissue integrity and potential for impaired tissue integrity with interventions to assess ulcerations every visit, provide education on ulcer and skin care, assess patient's ability to perform skin care upon admission and as needed. Review of the electronic record indicated that the patient had MRSA (documented on the banner bar) and nursing staff documented that the patient was on MRSA precautions. Review of the record failed to indicate that the plan of care was comprehensive to include the active MRSA infection. Review of the care plan with the Clinic Director on 10/16/18 at 12:55 PM verified that the plan of care failed to include the MRSA infection and should have.

    Review of the Nursing Plan of Care policy identified that the plan is kept current by

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ongoing assessments of the patient's needs and the patient's response to interventions, and updating or revising the plan in response to those assessments.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6).

20. Based on a review of facility documentation, interviews, and policy review, the hospital failed to develop a training program for the Lucas device (chest compression system) to ensure staff were competent prior to using the device. The finding includes:
    a. Review of the Code Pagers & Lucas (medical equipment that delivers 100 chest compressions per minute to cardiac arrest patients) Sign-in-sheet documentation during the period of 10/1/18-10/16/18 identified that eight (8) Patient Transporter staff were assigned pager #091 and #223. Review of facility documentation identified that when attending a cardiac code, from 6:00 am until 11:59 pm, the Transporter assigned to pager #223 obtains Lucas from the office and proceeds to the unit where the code is called and the Transporter with pager #091 responds to the code to assist with positioning Lucas and CPR if necessary. Documentation noted that providers are always in the room to ensure Lucas is properly positioned and to direct when to pause/continue CPR. Documentation further identified that Lucas is brought to the Emergency Department at 11:50 pm daily then picked up and brought to the transport unit office by transport staff at 6:00 am. Review of the Lucas training sign-in sheet dated week of 3/14/18-3/21/18 noted that a representative from the manufacturer conducted training. Two of the eight staff responsible for the Lucas device during the period of 10/1/18-10/16/18 were noted in this training session. Review of facility documentation and interview with the Unit Director on 10/16/18 at 11:00 am stated she was unable to provide evidence that all staff were trained on the Lucas device and/or was unable to provide curriculum for training and/or competencies. Interview with the Company Representative on 10/16/18 at 11:10 am stated the hospital calls him when they need staff trained on Lucas, the training is informal with no documentation of curriculum discussed and the facility maintains the attendance records. The hospital did not have a policy related to the use of the Lucas device. Review of the Performance Standards for the Patient Transport Department identified that all employees will be oriented to department specific policies, expectations, performance standards, and procedures by their direct Manager or Director.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3) and/or (i) General (6) and/or CGS 19a-127n.

21. *Based on a review of clinical records, facility documentation, interviews, and policy review, for one of the three patients' reviewed for surgical services (Patient #17), the hospital failed to

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ensure vaginal packing was removed prior to discharge and/or that the retained packing was reported to DPH as an adverse event and/or that the clinical record was accurate. The findings include:

a. Patient #17 was admitted to the hospital on 12/20/16 with a diagnosis of prolapsed bladder and scheduled for anterior colporrhaphy, retropubic urethral sling, and cystoscopy. Review of the operative report dated 12/20/16 identified that multiple incisions were made to complete the procedures. The record failed to identify that vaginal packing was utilized for post-operative hemostasis. Review of the post anesthesia care unit (PACU) record noted urinary output from the indwelling Foley catheter was 600 milliliters (mls) at 3:00 PM. A nurse's note identified that the MD was at the bedside for voiding trial and the patient voided 275 mls at 4:00 PM. The patient was discharged home at approximately 4:48 PM.

Interview with Patient #17 on 9/24/18 at 11:05 AM stated that at approximately 8:30 PM on 12/20/16, MD #20 called her at home and asked her to check to see if the surgical packing was still in place as she could not recall if she removed the packing before the patient left the hospital. Patient #17 identified that she removed the surgical packing and informed MD #20, who waited on the telephone line, that she (the patient) pulled out the surgical packing. Review of the operative report and interview with MD #20 on 10/16/18 at 3:00 PM stated vaginal packing would have been left in place to tamponade the incision, if more than one, as in this case. MD #20 further identified that the nurse usually removed the packing before the voiding trial, however, could not recall what happened in this case but stated the packing should have been removed prior to discharge.

Review of the discharge documentation identified that the procedures included; right salpingo-oophorectomy, perineoplasty, uterine suspension, and D&C. Review of the record with MD #11 on 10/16/18 at 2:40 PM identified that the clinical record was inaccurate based on a review of the operative report.

Review of the clinical record with MD #19 (OB/GYN Chief) on 10/16/18 at 2:40 PM stated she was unaware that vaginal packing was retained and if she was made aware, would have reported the incident to the Risk Department and initiated an investigation. Interview with Regulatory Readiness Specialist #1 on 10/16/18 at 3:30 PM stated the event was not reported to her Department therefore not reported to the Department of Public Health as an adverse event.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

22. *Based on clinical record review, staff interviews and review of documentation for 1 of 3 patients (Patient #2) reviewed for surgical safety, the hospital failed to ensure that a patient was

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transferred safely from the operating table. The findings include:

a. Patient #2 was admitted on 12/17/16 and underwent a planned surgical repair of a displaced fracture of the right proximal femoral shaft on 12/18/16. At the completion of the surgery, the RN Circulator was preparing the patient for transfer from the operating table (fracture table) to a stretcher when the patient fell from the operating table to the floor. The patient was stabilized, lifted back to the stretcher and transferred to the recovery room. Radiological imaging identified that Patient #2 sustained fractures of the 3rd through 9th posterior ribs, 3rd anterolateral rib as well as a left 1st anterior rib fracture. Patient #2 also developed a right pneumothorax that required the insertion of a chest tube and required pain medications for complaints of right sided chest wall pain throughout his/her recovery. Patient #2 was discharged on 12/23/16.

Interviews with MD #20, the Regional Director and Clinical Director on 9/27/18 at 12:10 PM identified that after Patient #2's surgical procedure was completed, the RN Circulator was preparing to transfer the patient from the OR table to the stretcher without another staff member present. The RN Circulator removed a positioning and traction pin from the table and cut tape from the foot of the patient's surgical leg. Once the tape was cut, the patient's leg slipped from the table and the patient's body slid off the table onto the floor, guided by the RN Circulator. Following the incident staff were reeducated on the use of the fracture table, boot alignment and use of the safety strap. The fracture table manufacturer provided additional education to OR staff and surgeons. In addition, process changes included all transfers to require 2 staff members and the positioning post is not removed until the patient is ready for transfer off the operating table. Audits have demonstrated compliance with the new practice.
The RN Circulator was not available for interview.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2) and/or (d) Medical records (3) and/or (i) General (6).

23. *Based on clinical record review, review of documentation and staff interviews for 1 of 3 patients (Patient #25) who was reviewed for surgical/procedural errors, the hospital failed to ensure that a surgical drain removal was documented in the clinical record. The findings include:

a. Patient #25 was admitted on 8/25/17 and underwent an surgical procedure of decompressive laminectomy of L1, L2, L3, L4 and L5 with drain placement at the surgical site. A nurses note dated 9/3/17 identified the drain was removed by PA #20. PA #20 did not document the drain removal. The patient was discharged on 9/11/17.

Patient #25 was admitted on 6/18/18 and on 6/21/18 underwent bilateral redo

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hemilaminectomies at L2 and L3 with no drains used. Patient #25 was discharged in stable condition on 6/26/18.

Patient #25 was readmitted 6/30/18 with acute encephalopathy, fever and concern for sepsis s/p laminectomy of 6/21/18. Due to the patient's history of organ transplant, he/she was transferred to another hospital familiar with the patient's transplant needs. An MRI revealed a fluid collection at the site of the laminectomy that could be a seroma, hematoma or abscess. The MRI also revealed a short segment of retained catheter at the level of L2-L3 presumed to be a piece of the drain from the 6/21/17 surgical procedure. The retained catheter segment was determined to be unrelated to the seroma and recommend to be left in place. Patient #25 was discharged on 7/6/18 with diagnoses of acute metabolic encephalopathy likely due to a central nervous system infection.

Interview with PA #20 on 10/4/18 at 11:00 AM identified that he saw Patient #25 on 9/3/17 and removed a surgical drain that was placed during a surgical procedure by another practitioner. PA #20 identified that his usual practice is to inspect the edges of a catheter on removal and although PA #20 did not recall this drain removal, he identified that if the catheter was not intact on removal, he would have notified the attending physician and ordered radiological images. PA #20 identified that although presumed to be a piece of surgical drain, it is undetermined exactly what was retained. In addition, PA #20 identified that although it was his usual practice to document the removal of a drain, in this case he did not document the drain removal.

Following the discovery of the presumed retained catheter segment the hospital educated all surgical team members regarding proper cutting and placement of drains and required documentation for removal. Audits have confirmed compliance.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

24. Based on clinical record review, interview and policy review the facility failed to ensure that for one record (Patient #36) reviewed for the initiation of preventative interventions for skin breakdown and/or that comprehensive skin assessments were completed. The findings include the following:
    a. Patient # 36 presented to the ED on 3/14/18 for congestive heart failure and was admitted. The clinical record indicated that the patient was discharged on 3/27/18 at 11:15 AM however returned to the ED on 3/27/18 at 2:50 PM. Review of the clinical record indicated that on 3/30/18 a sacral foam dressing was applied. The record failed to reflect the reason the dressing was applied and/or an assessment of the area. Review of the clinical record indicated that a wound consult was complete on 4/3/18 that indicated that the patient had a 3 cm by 0.5 cm by 0.1 cm partial thickness ulcer in

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the gluteal cleft area. The Wound consult note indicated that the plan was in part cleanse the skin and protect, and limit out of bed time to 1 hour three times a day. The record failed to reflect that these interventions were conveyed to the nursing staff and/or incorporated into the plan of care.

The note nurse's note dated 4/10/18 indicated that the patient had "pressure ulcers", the note failed to reflect an assessment of the area, measurements, stage and/or interventions. The wound consult note dated 4/10/18 indicated that the patient had a 2.2 cm by 2 cm wound. The note failed to identify the depth and/or stage of the wound. The note indicated that the patient stated she is out of bed to the chair for about four hours per day. The facility failed to ensure that weekly assessment of the wound was completed.

The patient was readmitted on 4/27/18, the wound care note dated 4/30/18 indicated that the patient had 3.5 by 3.5 by 1.1 pressure ulcer that was a stage 4. Interview and review of the medical record with the quality coordinator on 10/2/18 at 10:00 AM indicated that the record failed to reflect that an initial skin assessment had been completed at admission. Review of the policy indicated that an initial skin assessment should be completed by the RN within 8 hours of admission.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (i) General (6).

25. *Based on clinical record review, interview and policy review the facility failed to ensure that for one patient (Patient # 24) that medications were correctly reconciled at the time of admission. The findings include the following:
    a. Patient # 24 was admitted on 11/9/16 with abdominal pain vomiting and lethargy times one day. The patient has a past medical history on Diabetes and seizure disorder. The patient had an exploratory laparotomy on 11/9/16.

    Review of the medication list/history provided at admission indicated that Patient #24 was on Keppra 500 mg 3 tablets twice a day. The physician's orders dated 11/9/16 directed Keppra 500 mg 3 tablets twice a day. However review of the Medication Administration Record (MAR) indicated Keppra 500 mg twice a day.

    Review of the physician note dated 11/15/16 at 1:26 PM indicated that the patient was called by the nurse secondary to the patient having a seizure and had had one the previous day. The 11/16/16 at 8:20 AM note indicated that the patient has 8 seizures since 3:00 AM, Kepra and Ativan intravenous were administered and the group home was contacted for information. The 9:45 AM physicians note indicated that the patient is usually on Keppra 1500 mg BID at home. Although the patient's dose was corrected on 11/16/16 the patient continued to have seizures requiring transfer to the ICU and intubation and ultimately recovered.

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Interview with the Pharmacist on 10/2/18 at 12:15PM indicated that when the Medication History Technician (MHT) entered the orders (Keppra 500 mg 3 tablets twice a day) into the computer the MHT failed to enter the 3 tablets portion of the order. The pharmacist indicated that during the time the MHT was interrupted during the data entry. The Pharmacist indicated that since the incident several changes have been made to the process.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

26. Based on clinical record review, interview and policy review the facility failed to ensure that for one patient (Patient #3) presenting with patient that the patient's pain was thoroughly assessed and reassessed and/or the patient's status at discharge was assessed. The findings include the following:
    a. Patient #3 presented to the ED on 3/16/18 at 9:30 PM with post-operative back pain and lethargy. Review of the ED visit assessment indicated that the patient had a soft abdomen, non-tender with normal bowel sounds. The patient did have some mild leg pain to straight raises however the family felt this was similar to pre-operative abnormalities. The impression indicated that the patient had coccygeal pain with no falls or trauma, weakness and not eating.

    The nursing note at 9:34 PM indicated that the patient had complaints of back pain. The triage note indicated that the patient had "back pain prior to admission and received 5 mg of Oxycodone at 7:00 PM at the nursing home with minor relief, pain 10/10". The MD note dated 3/17/18 at 1:10 AM indicated that the patient may have a non-displaced sacral fracture, which would be treated by weight bearing as tolerated. The patient had a pain level of 8/10 at 1:42 AM and Hydrocodone was administered at 1:45 AM. The record failed to reflect a comprehensive pain assessment on admission and /or a reassessment of the patient's level of pain and/or efficacy of the intervention after the administration of the Hydrocodone. The patient was subsequently discharged on 3/17/18 at 3:00 AM, the record failed to reflect an assessment of the patient prior to discharge.

    Patient #3 presented to the hospital on 3/26/18 at 5:14 PM for atrial fibrillation, and pain in his/her sacral area. The physician's orders dated 3/27/18 at 2:25 AM directed Oxycodone 5 mg for moderate pain (level 4-6). The medication administration record indicated that 5 mg was administered at 4:02 AM. The record failed to reflect a comprehensive assessment of the patient's pain/ pain level at the time of administration.

    Review of the policy indicated that at the time of admission the RN will assess, and document the patient's pain. An initial assessment of pain will include but not limited to

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characteristics of pain, quality, severity, location, and region. The policy indicated staff should use the numeric scale for patients to self-report their level of pain. For patients receiving narcotic analgesics for acute pain staff assessment prior to the administration should include pain score, level of alertness, respiratory rate, and oxygen saturation. The patient's pain should be reassessed following each pain management intervention.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

27. Based on clinical record review, interview and policy review the facility failed to ensure that for one patient (Patient #3) identified as malnourished that a comprehensive assessment was completed and/or that staff addressed the patient's poor intake. The findings include the following:
    a. Patient #3 presented to the hospital on 3/26/18 at 5:14 PM for atrial fibrillation, additionally an outpatient x-ray identified a small left pleural effusion that was felt to be new. Review of the clinical record indicated that on 3/26/18 at 5:23 PM the patient's weight was 70.8 kg and on 3/27/18 at 3:00 AM the patient's weight was 53 kg. Review of the clinical record failed to reflect that staff re-weighed the patient after the 17.8 kg discrepancy.

       Review of the RD note dated 3/27/18 indicated that Patient #3 was a high nutritional risk and severely malnourished. The goals identified were oral intake greater that 75% of calculated needs by next assessment. Review of the 4/2/18 RD noted indicated that patient's oral intake was 0-50 % for five days.

       Review of the nursing documentation related to oral intake on 10/2/18 at 10:30 AM with the Quality Representative indicated that for the period of 3/27/18 through 4/1/18, the patient refused or ate 25 % for all meals except one meal that indicated 50% intake. The flow sheets indicated that from 4/2/18 through 4/4/18 the patient refused or ate 0% for all meals. Interview with the Dietician on 10/16/18 at 1:00 PM indicated that rounds are completed daily and indicated that when a patient is failing to meet the identified needs the nurse and/or the dietician can notify the physician. The RD indicated that she does not recall if the physician was notified. Interview with the MD #10 on 10/4/18 at 11:45 AM indicated that he does not recall being notified of the patient's poor intake. The facility failed to ensure that the patient's poor intake was addressed and/or that the physician was notified.

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

28. Based on observation, interview and policy review the facility failed to have a mechanism for staff to accurately perform a surgical scrub. The findings include the following:
    a. Tour and observation of the interventional radiology area on 10/16/18 at 10:00 AM identified that there were no clocks visible from the scrub sinks. Interview with the physician indicated that he washes his hands three times and that is at least 5-6 minutes. The physician indicated that he does a scrub initially and alcohol based hand gel thereafter.

       The policy indicated that when performing a surgical hand antisepsis using antimicrobial soap, scrub hands and forearms for the time recommended by the manufacturer, usually 2-6 minutes.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2) and/or (e) Nursing service (1) and/or (i) General.

29. *Based on clinical record review, facility documentation and interviews for one of three sampled patients (Patient #1) reviewed for post procedure assessment, the facility failed to re-assess the hematoma at the biopsy site prior to discharge. The findings include:
    a. Pt #1 was admitted to interventional radiology on 8/2/18 for an ultrasound guided right renal mass biopsy, the patient's diagnoses included a 3.6cm x 3.2cm solid mass on the right kidney.

       Review of the biopsy procedure notes identified procedure start at 10:04AM with moderate sedation. The post biopsy imaging identified formation of a hematoma surrounding the renal mass therefore no further biopsies were obtained and the procedure ended at 10:37AM. At 11:08 AM Patient#1 underwent a CT scan of the abdomen which identified a moderate size perinephric hematoma arising from the right renal mass, no further biopsies were attempted and the patient was out of the room at 11:28 AM.

       The PACU vitals and assessment flow sheets identified vital sign documentation at 12:00PM BP 127/77 P 67 R18; 12:15PM BP 118/99 P 66 R19; 12:30PM BP121/77 P79 R18 and at 12:45PM BP 107/59 P85 R19.

       The clinical record identified the patient was seen by MD#5 and cleared for discharge home.
       The ED record dated 8/2/18 at 2:23PM identified Pt#1 had witnessed syncopal episodes

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

at home and brought to the ED for further evaluation. A repeat CT scan of the abdomen demonstrated a large retroperitoneal hematoma measuring 15.6 CM x 10.1CM x 7.5CM. In addition the patient's hemoglobin level had dropped from baseline 10g/dL (Reference range 13.0-17.7g/dL) to 8.2 g/dL and 7.8 g/dL. Pt#1 was admitted due to acute blood loss anemia secondary to retroperitoneal hematoma. The discharge summary dated 8/4/18 identified orthostatic hypotension in the setting of a retroperitoneal bleed.

In an interview on 9/28/18 at 1:00PM, MD#5 identified during the procedure it was difficult to visualize the area after biopsies were taken due to bleeding. MD#5 identified he had seen the patient prior to discharge and recalled the patient's vital signs were stable. MD#5 identified he was informed that the patient was readmitted due to a retroperitoneal bleed. In addition, MD#5 identified because of the hematoma at the biopsy site, scanning the area prior to the patient being discharged should have been considered.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6).

30. Based on observations, interview of hospital staff, and an interview of the Radiation Safety Officer and a review of documents pertinent to the radiation protection program of Bradley Memorial Hospital the following violations were noted:

    a. Section 19-24-8 "Radiation Information Labeling" states:

    Each area or room in which sources of ionizing radiation other than radioactive materials are used shall be conspicuously posted with a sign or signs bearing the radiation caution symbol and appropriate wording to designate the nature of the source or sources of ionizing radiation (example below)

    CAUTION *
    X-RAY
    Additionally, section 19-24-8 also states: CAUTION *
    RADIATION AREA

    This provision shall not apply to areas or rooms where x-ray equipment is used solely for diagnostic purposes by or under the direction of a healing arts practitioner as authorized by law"

    Contrary to this, X- Ray rooms one and two which utilized X-Ray were posted "Caution Radiation Area" and signs were not posted on all entrances to the rooms. Additionally, the Emergency Room (room five) had no posting at the patient entrance and the technician work area was incorrectly posted.

DATES OF VISIT: Commenced on September 24, 2018 and concluded on October 24, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Section 19-24-9 "Shipment in Compliance with Federal Regulations"
Contrary to this after a review of documents it was determined that staff who were involved in the transportation process of radioactive material had not received 49 CFR Part 172 Subpart H Training for Hazmat Employees. It was noted that this was a self-identified deficiency and the Hospital of Central Connecticut is working to rectify this.

Approved 3/6/19 SHN

ATTACHMENT 1

The filing of this Plan of Correction (PoC) does not constitute any admissions to any of the alleged violations set forth in this statement of deficiencies. It is being filed as evidence of continued compliance with all applicable laws and the facility's desire to continue to provide quality services. The facility requests this PoC be considered as its allegation of substantial compliance.

Prefix ID	Corrective Measure(s) and Follow-up Measures	Completion Date	Responsible Staff by Title
1.a. - d. through 7.a. - ,b.	Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. To ensure needed input, an interdisciplinary team representing key stakeholders was organized on 10/24/2018 including, nursing and medical staff leaders, clinical resource leaders, nursing/clinical educators, clinical informatics and analytics, quality and safety and HHC system reps of the Restraints and Seclusion Council. Key components of this PoC include the following and are discussed in greater detail throughout this response. • Staff education and awareness communications for nurses and providers • Documentation expectations and staff accountability • Restraints and Seclusion Policy review • Electronic health record revisions to restraints nursing flow sheet for improved documentation • Monitoring and feedback to ensure appropriate documentation Leadership is engaged and committed to ongoing monitoring of outcomes through the following processes: - Monthly review of the plan of corrections and audit results at the Performance Improvement Coordinating Council (PICC) meetings beginning November 2018. - Monthly Quality Assessment and Performance Improvement review of Plan of Correction (PoC) and audit results until acceptable results are met beginning November 2018. - As part of the overall QAPI reporting plan the PoC and audit results will be reviewed quarterly by the Hospital Board beginning December 2018.	11/21/2108	Director, Patient Care Services Medical Director, Hospitalists
***1.a. - d.**	**Clarification**: Reference is made in the violation letter of failure of the facility to have a policy for the use of chemical restraints. Because this facility does not chemically restrain patients, it does not have a chemical restraint policy. **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to Medical Staff to ensure daily documentation in the medical record includes a comprehensive assessment for the use of PRN psychoactive medications and/or a response to the medication. a. Verbal communication was provided to the Medical Staff starting 10/24/18; formal education of the Medical Staff was completed by the Site Director, Division of Hospital Medicine on 10/26/18, Chief of Emergency Medicine on 11/6/18. 2. Education was provided to nurses that the patient will be reassessed for effectiveness of medication, as appropriate, following administration of PRN antipsychotic medications by evidence of documentation in the medical record. a. Verbal communications, daily safety huddles and email communications provided to nursing staff starting 10/24/18; electronic nurse education module was assigned to nurses on 11/21/2018 for restraints documentation, including documenting effectiveness of PRN antipsychotic medications. <u>Auditing</u>: Audit 10 records per month of patients on PRN psychoactive medications to ensure that daily documentation in the medical record includes a comprehensive assessment for the use of PRN psychoactive medications and/or a response to the medication post-administration. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 95% or better compliance achieved.		

2.a. - d.	The physician and nursing documentation failed to correctly specify the reason for the restraint type. As a result the following plan was put into place: **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to Medical Staff to ensure documentation for the restraint order specifies justification and type of restraint. a. Verbal communication was provided to the Medical Staff starting 10/24/18; formal education of the Medical Staff was completed by the Site Director, Division of Hospital Medicine on 10/26/18, Chief of Emergency Medicine on 11/6/18. 2. Education was provided to nurses for restraint use and documentation: a. Patient behaviors must be documented and appropriate for the restraint type b. If two types of restraints are used, justification and monitoring will be specific to each restraint and will have distinct documentation. c. Nursing documentation of least restrictive interventions considered, and, d. If restraint is no longer justified, least restrictive interventions will be used and nurse will remove restraints, i.e. if patient sleeping for extended time. i. Verbal communications, daily safety huddles and email communications provided to nursing staff starting 10/24/18; electronic nurse education module was assigned to nurses on 11/21/2018 addressing items 2.a-d. Auditing: Audit 10 records per month of patients in non-violent restraints to ensure that daily documentation in the medical record is met for providers and nurses. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 95% or better compliance achieved.	11/21/2018	Director, Patient Care Services Medical Director, Hospitalists
***3.a. - e.**	5 of 10 records failed to show consistent documentation in the medical record that least restrictive measures were utilized. As a result the following plan was put into place: **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to Medical Staff to ensure documentation for the following: a. Daily provider documentation for the restraint must include type of restraint and the reason for restraint. b. Least restrictive interventions will be used when the restraint is no longer justified. i. Verbal communication was provided to the Medical Staff starting 10/24/18; formal education of the Medical Staff was completed by the Site Director, Division of Hospital Medicine on 10/26/18, Chief of Emergency Medicine on 11/6/18. 2. Education was provided to nurses for restraint use and documentation: a. Patient behaviors must be documented and appropriate for the restraint type b. If two types of restraints are used, justification and monitoring will be specific to each restraint and will have distinct documentation. c. Nursing documentation of least restrictive interventions considered, and, d. If restraint is no longer justified, least restrictive interventions will be used and nurse will remove restraints, i.e. if patient sleeping for extended time. i. Verbal communications, daily safety huddles and email communications provided to nursing staff starting 10/24/18; electronic nurse education module was assigned to nurses on 11/21/2018 addressing items 2.a-d. Auditing: Audit 10 records per month of patients in non-violent restraints to ensure documentation of least restrictive measures utilized in the medical record is met for nurses. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 95% or better compliance achieved.	11/21/2018	Director, Patient Care Services Medical Director, Hospitalists

4.a.	In 1 of 10 medical records reviewed documentation failed to show that restraints were discontinued at the earliest time possible. As a result the following plan was put into place: **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to Medical Staff to ensure documentation for the following: a. Daily provider documentation for the restraint must include type of restraint and the reason for restraint. b. Least restrictive interventions to be used when restraint no longer justified with intent to discontinue as soon as possible. i. Verbal communication was provided to the Medical Staff starting 10/24/18; formal education of the Medical Staff was completed by the Site Director, Hospital Medicine, on 10/26/18, Chief of Emergency Medicine on 11/6/18. 2. Education was provided to nurses for restraint use and documentation: a. Patient behaviors must be documented and appropriate for the restraint type b. If restraint is no longer justified, least restrictive interventions will be used and nurse will remove restraints, i.e. if patient sleeping for extended time. i. Verbal communications, daily safety huddles and email communications provided to nursing staff starting 10/24/18; electronic nurse education module was assigned to nurses on 11/21/2018 addressing items 2.a-d. Auditing: Audit 10 records per month of patients in non-violent restraints to ensure documentation of least restrictive measures utilized in the medical record is met for nurses. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 90% or better compliance achieved.	11/21/2018	Director, Patient Care Services Medical Director, Hospitalists
***5 a. – c.**	In 3 of 10 records reviewed, the provider failed to consistently document restraint behaviors and/or assessments in the daily provider note. As a result the following plan was put into place: **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to Medical Staff to ensure documentation for the following: a. Daily provider documentation for the restraint must include assessment, including type of restraint and the reason for restraint as evidenced by patient behaviors. i. Verbal communication was provided to the Medical Staff starting 10/24/18; formal education of the Medical Staff was completed by the Site Director, Division of Hospital Medicine on 10/26/18, Chief of Emergency Medicine on 11/6/18. Auditing: Audit 10 records per month of patients in non-violent restraints to ensure daily provider notes document restraint behaviors and/or assessments. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 90% or better compliance achieved.	11/21/2018	Medical Director, Hospitalists
6.a. - c.	In 1 of 10 records reviewed, the nurse failed to consistently document restraint behaviors and/or assessments every 2 hours. As a result the following plan was put into place: **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to nurses for restraint use and documentation: a. Patient behaviors must be documented every 2 hours when a patient is in restraints. b. If two types of restraints are used, patient behaviors and monitoring will be specific to each restraint and will have distinct documentation. i. Verbal communications, daily safety huddles and email communications provided to nursing staff starting 10/24/18; electronic nurse education module was assigned to nurses on 11/21/2018 addressing items 2.a-d. Auditing: Audit 10 records per month of patients in non-violent restraints to ensure nurse documents restraint behaviors/assessments every 2 hours. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 90% or better compliance achieved	11/21/2018	Director, Patient Care Services

*7.a. - b.	In 2 of 10 records, the provider failed to document adequate justification for the use of more than one restraint. As a result the following plan was put into place: **Corrective Action Plan:** Prior to surveyor exit, an immediate Plan of Correction (PoC) for improving restraints documentation was submitted on 10/24/2018. 1. Education was provided to Medical Staff to ensure documentation for the following: a. Daily provider documentation for the restraint must include type of restraint and the reason for restraint. b. If 2 types of restraints are used, daily justification and documentation must be specific and distinct to each restraint type ordered. i. Verbal communication was provided to the Medical Staff starting 10/24/18; formal education of the Medical Staff was completed by the Site Director, Division of Hospital Medicine on 10/26/18, Chief of Emergency Medicine on 11/6/18. Auditing: Audit 10 records per month of patients in non-violent restraints to ensure provider documents adequate justification for the use of more than one restraint. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved. As of 2/2019, audits have been completed for December 2018 and January 2019 with 90% or better compliance achieved	11/21/2018	Medical Director, Hospitalists
*8.a.	Because the facility failed to ensure one patient dialyzing had his access site visible at all times, the below measures were put in place. Note: Effective 9/30/2018, Outpatient Dialysis is now under a change of ownership with DaVita. All findings were shared with Davita Leadership. **Corrective Action Plan:** 1. Immediately following recognition that a patient's access site was not visible, site visibility was obtained, the patient was re-educated to keep the access site visible and initial safety awareness was communicated to all dialysis patient care personnel regarding the need to ensure continued visualization of dialysis access sites during hemodialysis treatments. Completed: 09/25/18 2. Beginning 9/25/2018, all staff will participate in department-specific daily safety huddles which will include the importance of staff ensuring the access site is visible throughout the dialysis treatment. To be completed: 10/02/2018 3. Verified the current Dialysis Procedure Manual Policy, *Braun Dialysis Treatment Initiation*, included language to ensure dialysis access is visualized at all times throughout the hemodialysis treatment. Completed: 09/25/18 4. Beginning 9/25/18, all nurses will be re-educated to document in the patient's Plan of Care for patient understanding of keeping access site visible at all times during hemodialysis treatments. To be completed: 10/02/2018 5. Beginning 9/25/2018, all hemodialysis patients will receive an educational handout on the importance of keeping the dialysis access site visualized at all times during hemodialysis treatments. Completed: 10/02/2018. Auditing: A daily access visualization audit will be performed by the Dialysis Clinical Manager or designee for one week, beginning 9/25/18, and then weekly for 3 months.	10/02/2018	Clinical Manager, Dialysis
*9.a.	Note: Effective 9/30/2018, Outpatient Dialysis is now under a change of ownership with DaVita. All findings were shared with Davita Leadership. Because the facility failed to ensure following an unscheduled reverse osmosis sanitation, that the water loop was tested for absence of sterilant prior to the start of the treatment day, the following measures were put into place: **Corrective Action Plan:** • Immediately following recognition that the technician safety check was not documented, the facility departments involved with the RO sanitization process were immediately notified and an immediate plan was discussed to ensure securement of the water room and notification of all disciplines involved in the RO sanitization moving forward. Staff education was initiated on 9/26/18 and will be completed by 9/28/18 for facilities, biomedical engineering and hemodialysis staff. The below steps 1-5 were reviewed: 1. Beginning 9/26/2018, the process for unscheduled RO sanitization that is completed by the RO system maintenance provider will be as follows: The Dialysis staff will be responsible for notifying the Plant Operations and Maintenance Department at ext. 5440 to inform them that the RO system was put on de-ionization, DI. 2. The Plant Operator will contact The RO system maintenance provider and the on-call Biomedical Engineering tech to notify them that technicians will be needed to sanitize the loops later in the day after patient treatments are completed.	9/28/18	Clinical Manager, Dialysis

	3. The RO system maintenance provider will sign-in in the Plant Operations and Maintenance Department upon arrival. The Plant Operator will then page the on call Biomedical Engineering Technician who will escort the RO system maintenance provider to the Dialysis Unit. 4. In a coordinated effort, the RO system maintenance provider will sanitize the loop; Biomedical Engineering will sanitize from the wall station to the machines and will verify after the rinse by documentation in the monthly RO Sterilization Log that the stations and machines are absent of sterilant. 5. The morning following the sanitization, the Dialysis technicians will perform a safety check of the RO loop at each station and will document absence of sterilant results on the RO sanitization negative Minncare Log prior to the initiation of patient treatments. 6. The 5:30 AM RN will verify PCT documentation of safety checks following RO system maintenance on the RO sanitization negative Minncare Log. • The RO system maintenance provider will confirm via email that all their technicians have been educated and are aware of the below hospital expectations. 1. The Tech must sign in with Plant Operations and maintenance upon arrival. 2. The Tech will be escorted to the Dialysis unit to perform service. 3. The Tech must sign out in Plant Operations and maintenance when leaving the facility. The Tech will leave the service slip with Plant Operations and Maintenance verifying that the system is absent of disinfectant. <u>Auditing:</u> • The Dialysis Clinical Manager or designee will verify appropriate Technician and RN documentation of the RO Sanitization Negative Minncare Log for 3 months until 100% compliance is achieved, beginning 9/26/18. • The Director of Biomedical Engineering will verify documentation in the monthly RO Sterilization Log that the stations and machines are absent of sterilant and the petlock is secured for 3 months until 100% compliance is achieved, beginning 10/01/18.		
Items 10.a. thru 18.a. – b.	Effective 9/30/2018, Outpatient Dialysis is now under a change of ownership with DaVita. All findings were shared with Davita Leadership.		DaVita Leadership
19.a. – b.	Because the Clinic failed to ensure documented plans of care included contact precautions, the below measures were put in place. **Corrective Action Plan:** 1. Care plans have been built into the electronic health record. and are no longer on paper so as to prevent double documentation. Staff educated at huddle. Effective 11/27/18 2. All paper care plans were transferred onto the Epic version and old paper copies were scanned into Epic under the media tab. 3. A section was built into Epic care plans under soft tissue infection with MDRO's as a line item where type of organism and type of precaution can be listed. Effective 1/28/19. 4. Staff educated regarding new MDRO section at staff meeting on 2/8/19. <u>Auditing:</u> <u>Audit 10 records (or 100% if less than 10) per month of patients with MDRO's to ensure that organism and type of precautions is documented in the patient's care plan. Monthly monitoring will continue until 3 months at 90% or better compliance is achieved.</u>	2/08/2019	Wound Care Program Director
20. a.	Because the facility failed to develop a training program for the Lucas device (chest compression system) to ensure documentation was available that transport team staff were competent prior to using devices, the below measures were put in place. **Corrective Action Plan:** 1. Transport Team members received re-training for the Lucas Automated Compression Device, including application and utilization. Participants were required to: a. Demonstrate appropriate application and utilization technique of the Lucas device. b. Identify key factors that correlate with high quality compressions while utilizing the Lucas device c. Identify maintenance needs. 2. Staff must participate in training before responding with Lucas device.	11/08/2018	Director of Transport Team

	Ongoing Monitoring: As part of new hire orientation, the Director of Transport Team or designee will monitor staff for participation in Lucas Training and conduct direct observations/skill validation to ensure Lucas equipment competency prior to staff assignment as Lucas device responder. All staff will participate in Lucas training and skill validation annually, thereafter.		
***21.a.**	Because the facility failed to ensure vaginal packing was removed prior to discharge and/or retained packing was reported to DPH as an adverse event and /or the clinical record was accurate, the below measures were put in place. Clarification: This patient's experience was not known to the facility until it was reviewed at time of survey. In review of the case, the patient was discharged home same day as surgery from the PACU. Upon calling patient that night her surgeon instructed her to remove the vaginal packing. Acceptable scenarios for removal of vaginal packing following discharge same day are to: 1) Remove packing prior to discharge, 2) Leave vaginal packing in place (24 hours) with follow-up in MD office the next day for removal, 3) Instruct patient to remove it at home if patient felt comfortable with that plan. The packing was inserted in the OR and left in (retained) intentionally by provider; however, it was not removed prior to discharge by provider and there were no documented instructions for removal at home or in the office as an outpatient. In January 2018, the provider involved in this case relocated to another state. It should be noted that practice by other providers at this facility is to admit patient overnight and remove packing the next day prior to discharge. **Corrective Action Plan:** 1. Current practice is for Residents to sign out all GYN patients. As part of the sign out list, the Resident must indicate whether the patient had packing and whether or not packing is in place or has been removed. Initiated October 2016. 2. The issue of vaginal packing was discussed at OB Council, including documentation of packing insertion and removal. June 2018 3. At the OB/GYN Business Meeting, the Director of Quality reviewed the event reporting process. Completed 6/13/2018. 4. The Chief of OB/GYN issued a provider communication of the below items. Completed 2/15/19. a. When packing is inserted in the OR it should be documented in the op note. b. To issue a nursing communication in the patient record when vaginal packing is placed and when removed. c. If patient is being discharged with vaginal packing in place for removal at a later time, provider instructions should be clearly communicated with the patient and the follow up plan should be stated in the patient's discharge instructions. d. Provider awareness to check the Resident's sign out sheet is important when discharging a patient home early or from the PACU as this may be prior to the Resident removing the packing. The Residents always document the packing status on their sign out sheets. e. An unintended retention of foreign object; including packing, is a reportable event and is to be reported to the Department Chief and Quality and Safety Department for reporting purposes. A Quantros event is to be completed for event review. Monitoring Plan: This is a low frequency procedure as vaginal packing is used by generalists for limited vaginal surgery 2-5 episodes per year. All OB/GYN providers received an awareness communication which will be reviewed with providers annually and with residents at the start of their rotation.	2/15/2019	Chief of Ob/GYN and Chairman of Peer Review for the Department of OB/GYN ✓
***22.a.**	Because the facility failed to ensure that a patient was transferred safely from the operating table, the below measures were put in place following review of the event in 2016. **Corrective Action Plan:** 1. Education memo sent to all Orthopedic Divisions, PA's, Anesthesia and Perioperative staff regarding the event, contributing issues, and below improvement plan. Communications were sent on 12/23/2016 and on 01/19/2017. a. A minimum of two persons are to be at bedside assisting with patient positioning and take down of bed. b. Bed strap is to be used during procedure to secure the patient. c. The Safety Post is to be removed just prior to transfer of patient to hospital bed. 2. The Fracture Bed Vendor provided on-site in-services with perioperative staff regarding bed mechanics on 01/11/2017. 3. A staff re-education memo was provided to perioperative staff on 03/29/2018.	3/29/2018	Chief of Surgery and Director of Perioperative Services ✓

	Auditing: The OR Manager or designee audited 100% of all cases using the fracture bed from January - March 2017 to ensure a minimum of two persons are assisting with patient positioning and take down of bed, that bed strap is used during procedure to secure the patient and the Safety Post is removed just prior to transfer of patient to hospital bed. A repeat audit performed March - April 2018 to ensure compliance with proper safety measures confirmed 100% compliance.		
***23.a.**	Because the facility did not ensure that removal of a surgical drain was documented in the clinical record, the below measures were put in place. **Corrective Actions:** 1. Education memo sent to all Surgeons/PAs/Residents/APRNs, and Peri-op Leaders regarding Management of Surgical Drains - Insertion, Removal and Documentation on 8/23/2018. Education included documentation following removal of surgical drain should include tip of drain intact at time of removal. If tip not found intact and imaging should be done. 2. Case reviewed to share awareness of event at Surgical Business Meeting on 9/13/2018. Auditing: Audits (10 per month or 100% if less) on surgical drains removed during inpatient stay from September – December 2018 to ensure documentation that tip of drain intact at time of removal and imaging done if tip not found to be intact. Audits will continue until 90% compliance or better is achieved for 3 consecutive months.	9/13/2018	Chief of Surgery and Manager of Surgical PAs
24.a.	Because the facility failed to ensure that of one record reviewed that initiation pf preventative interventions for skin breakdown and/or that comprehensive skin assessments were completed, the below measures were put in place. **Corrective Actions:** 1. Nursing education was provided via monthly nursing electronic learning module regarding proper Wound Care use for any type of pressure injury. Completed 7/01/2018. 2. Wound Care RN's developed running daily report of tracheostomy patients for review and to provide additional physical assessment. Initiated 6/01/2018. 3. Education communication was sent to surgeons performing tracheostomy procedures to emphasize use of proactive foam under tracheostomy plate. Completed 5/11/2018. Auditing: Wound Care Specialist runs daily report of tracheostomy patients in hospital and provides additional assessment to ensure corrective wound prevention items are in place. Since implementation in May 2018, tracheostomy wound prevention measures have been monitored appropriately and with no lapses in patient assessments and preventative interventions.	7/01/2018	Wound Care Specialist
***25.a.**	Because the facility failed to ensure for one patient that medications were correctly reconciled at the time of admission, the below measures were put in place. **Corrective Action Plan:** 1. Education provided November – December 2016 regarding medication history process was reviewed with all medication history techs with emphasis on decreasing distractions during medication history process though: • New signage developed and placed where medication history is being performed • New voicemail set up for medication technicians so they are not interrupted by calls and can respond later 2. Communication sent to providers to inform them about reducing distractions during medication history. December 2016. 3. Medication history audits initiated on each medication history tech to evaluate compliance with process and evaluate errors. Audits were performed from November 2016- February 2017 and repeated March 2018 - August 2018. 4. Communication regarding the role of the medication history process sent out to providers and defined roles clarified between history collection and medication reconciliation. Completed December 2016. 5. Medication history technician involved in discrepancy was coached and educated December 21, 2016. Auditing:Audits were performed on all Medication History technicians from November 2016 - February 2017 to ensure medication techs are not interrupted or distracted during the medication history process. Repeat monthly audits were conducted March 2018 - August 2018 to ensure standard practice.	12/21/2016	Pharmacy Director

26.a.	The facility failed to ensure that a patient's pain was addressed in the Emergency Department. The following plan has been put into place: **Corrective Action Plan:** 1. Education was provided to ED nurses regarding pain reassessment documentation requirements via email and expectations reinforced at daily safety huddles. Completed 02/18/19. 2. All ED RNs were assigned education, Pain, Care of the Adult Patient With. Completed 02/18/19. Auditing: ED Nurse Manager or designee to audit 20 patient records per month for appropriate documentation of pain assessment until 90% or better compliance is achieved for 3 consecutive months. Monitoring will include pain assessments documented every 4 hours for pain level greater than zero, provider notification of pain levels over 7, discharge documentation that pain addressed or rationale for not providing intervention, re-evaluation of pain score 30-60 minutes after parenteral pain medication and 60-120 minutes after oral pain medication administration.	2/18/2019	Nurse Director, Emergency Nursing
27.a.	Because the facility failed to ensure that for one patient identified as malnourished that a comprehensive assessment was completed and/or that staff addressed the patient's poor intake, the below measures were put in place. **Corrective Actions Plan:** 1. Reviewed policy to appropriately assess risk and follow-up timeline with RD team. High-risk patients, including those with malnutrition, should be monitored on a shorter timeframe so if patient is not meeting nutrition goals the interventions can be adjusted in a more timely fashion. Completed 10/17/18. 2. Reviewed malnutrition documentation policy with RDs. Completed 10/17/18. 3. Re-educated and coached RDs on how to appropriately communicate nutrition status of a patient with medical team, verbally and via documentation in the patient's electronic health record. Completed 10/17/18. 4. Re-educated RDs who documented on patient how to properly evaluate patient's progress towards nutrition goal and adjust care plan as necessary. In this case, the RDs were coached on recommending alternate nutrition intervention to help patient meet nutrition goals after seeing no progress between initial and follow-up assessment. RDs were also coached on communicating recommendations to medical team both verbally and in person. Completed 10/17/18. Auditing: The clinical nutrition team will have quarterly chart audits completed on a range of patients, including those identified with malnutrition or at high-risk, to ensure that nutrition documentation meets policies mentioned above and that sound clinical judgement is used. Specifically, the dietitian interviewed in this case will be monitored on a more regular basis with 1:1 meetings. Audits for documentation compliance will continue until 90% or better compliance for 3 consecutive months is achieved. Any score less than 90% will be responded to with a performance improvement plan for the RD. These chart audit scores are communicated with the dietitians and any findings are reviewed with them individually.	10/17/18	Senior Director, Food and Nutrition
28.a.	Because the facility failed to have a mechanism for staff to accurately perform a surgical scrub in interventional radiology, the below measures were put in place. **Corrective Action Plan:** 1. At time of survey, an immediate response resulted in a clock being placed in the location where surgical scrubs are performed to allow staff a means of accurately timing the surgical scrub. Completed 10/17/2018. 2. The Interventional Radiology team performing surgical scrubs was educated on the use of the clock for appropriate timing of the scrub procedure. Completed 10/26/2018. Auditing: Weekly direct observational audits were conducted of IR staff during the month of October –November to ensure proper surgical scrub technique was practiced for the appropriate 3 minute duration. Periodic monitoring is performed with immediate feedback to staff, as needed. Results are reported to the Clinical Director of Interventional Radiology.	10/26/2018	Clinical Director, Interventional Radiology

***29.a.**	Because the facility failed to re-assess the hematoma at the biopsy site prior to discharge, the below measures were put in place. Clarification: In review of this case, the patient's vital signs were stable following the procedure. The provider assessed the patient while in PACU post-procedure and cleared the patient for discharge. It was during the routine post-procedure follow-up call next day made by the Interventional Radiology nurse that the nurse learned the patient had been admitted to the hospital the previous day. The nurse notified the provider; however the nurse failed to notify the Clinical Director that the patient had been admitted. Furthermore, the event was not entered in the hospital's event reporting system. **Corrective Action Plan:** 1. The Clinical Director of Interventional Radiology provided a communication to all interventional radiology nurses that when a patient identified during the post-procedure follow-up call next day is admitted to the hospital, the nurse is to notify the provider and the Clinical Director so that a case review can be initiated. Furthermore the event is to be entered in the hospital's event reporting system. Completed 2/18/2019. Monitoring Plan: 100% of all IR nurses will attest to reading and understanding performance expectations per the above communication. Any event entered in the hospital's event reporting system related to the IR patient experience will be reviewed.	2/18/2019	Clinical Director Interventional Radiology
30.a. **Part I**	Because the facility failed to ensure appropriate "caution" signs were posted with radiation caution symbol at entrances of an x-ray room, the below measures were put in place. **Corrective Action Plan:** All areas that utilize Ionizing Radiation were evaluated for appropriate signage. The correct posting was permanently affixed where the appropriate "Caution" sign was lacking or incorrect sign was posted. Completed 10/01/18. Auditing: The Manager of Diagnostic Imaging, or designee, will verify quarterly that all required caution signs are posted. Any signs found to be missing or damaged will be replaced immediately.	10/01/2018	Manager of Diagnostic Imaging
30.a. **Part II**	At time of survey, department leadership identified a gap related to DOT hazmat training documentation for selected department staff. Department leaders have put in place the following measures: **Corrective Action Plan:** 1. All Nuclear Medicine technologists completed DOT Hazmat Training as required under 19-24-9. Completed 11/09/18. 2. Documentation of DOT Hazmat training will be retained in department files for ongoing monitoring. Completed 11/09/18. Monitoring Plan: The Manager of Nuclear Medicine will verify that all Nuclear Medicine technologists maintain documentation compliance with DOT Hazmat training as required under 19-24-9. Participation will be verified during new hire orientation and annually with required retraining training conducted every two years.	11/09/18	Manager of Nuclear Medicine